

A Model for Soldier Psychological Adaptation in Peacekeeping Operations¹

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ABSTRACT

The U.S. military has little experience with United Nations-led peacekeeping missions. How well combat-trained units and soldiers adapt to this new role is of critical importance to U.S. ability to contribute to such operations, as well as to continued force readiness. This report summarizes findings on three U.S. Army units that recently served in peacekeeping operations in the former Yugoslavia, and presents a model of the underlying psychological issues in soldier adaptation to such operations. The focus of each investigation was on identifying the key sources of stress for soldiers, and delineating the impact of these stressors on the health, morale and mental readiness of soldiers. Findings show that degree of overall stress is correlated significantly with days of depression in all groups examined, indicating clear effects of stress on mental readiness and performance. A five-dimensional model represents the key issues in psychological adaptation to peacekeeping operations: Isolation, Ambiguity, Powerlessness, Boredom, and Danger. This model leads to several recommendations for "counter-measures" that organizational leaders can take for maintaining soldier psychological readiness throughout peacekeeping operations.

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A Model for Soldier Psychological Adaptation in Peacekeeping Operations

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As U.S. Army forces in the post-Cold War Europe assume more contingency and peacekeeping operations throughout the European theater and Africa, Army research psychologists in Europe have focused attention on understanding the human and psychological dimensions of such missions. This paper summarizes results of a three studies of Army units involved in peacekeeping operations in the former Yugoslavia, and presents a conceptual model for understanding the underlying psychological features salient to soldier adaptation to peacekeeping operations. After a brief description of the methods and samples used, we address the following questions:

1. What stressors are encountered in peacekeeping operations?
2. What are the relations between stress and health outcomes?
3. What is the possible relation between stress and alcohol use?
4. What "universal" issues emerge across multiple deployments?
5. What are the underlying psychological issues behind the "laundry lists" of stressors identified?

METHOD: In November of 1992, the U.S. Army was given the mission to provide medical support to 25,000 United Nations peacekeeping forces (UNPROFOR) operating in the former Yugoslavia. A Task Force of about 300 U.S. soldiers was dispatched from Germany for a six-month deployment. A behavioral scientist specialist deployed with the unit and conducted observations throughout the deployment. Also, a survey instrument was administered about half-way through the deployment, and then a modified survey was administered in the late-deployment phase.

In March of 1994 a second U.S. Army unit in Germany was deployed for the medical support mission. Data collection with this unit began in the period prior to their actual deployment to Croatia. Over a two-week training course, 74 semi-structured interviews were done, and 188 surveys completed by soldiers. Extensive observations were also conducted throughout this period. A two-person "Human Dimensions Research Team" made a total of four data collection site-visits to the unit in Croatia over the course of the deployment, staying for 7-10 days per visit. The first visit covered the initial arrival and transition period, with subsequent visits 2-months and 4-months into the deployment. The third site visit utilized a larger research team of four members, administering a survey as well as conducting interviews and observations. The final visit occurred near the end of the mission, about 2 weeks prior to re-deployment.

In July of 1993 an Army infantry unit based in Germany deployed to Macedonia to perform a conventional border patrol or "observe and report" peacekeeping mission. Immediately upon completion of their 6-month rotation, they were administered a survey at their home station. Table 1 summarizes the key features of three samples.

Despite some variations, all surveys used similar or identical items and covered the same three general areas: (1) sources of stress; (2) physical and mental health outcomes (including morale); and (3) individual and organizational factors that might influence responses, both positive and negative, to stress. We were also interested to observe how unit cohesion develops in newly-constituted units like this, and how soldiers adapt to a multi-national operational environment.

RESULTS: The second medical support unit was studied most extensively, and provides a valuable reference point. Though built around an existing core element, the unit was specially constituted to serve the peacekeeping mission. Personnel for the unit, which increased in size from about 30 to about 200 people, were drawn mainly from two locations in Germany, with others coming from widely dispersed communities. While it is increasingly common for deploying units to have personnel and equipment specially tailored for the mission, the situation was extreme for this unit. This provided an unusual opportunity to gain insight into the kinds of problems confronted by units preparing for deployment on contingency operations.

There was considerable confusion early on regarding the make-up of the unit. Many of the soldiers were complete strangers, and most key leaders were new in their jobs and not yet recognized by the soldiers. A debate among senior commanders about how to staff the unit created additional uncertainty that was not resolved until shortly before the actual deployment. This meant that in the pre-deployment period, many unit trainees were unsure about whether they would actually be part of the mission. Overall, the major stress factor in the pre-deployment was the uncertainty associated with getting to know peers and leaders, and finding out who was going and when.

There was substantial concern about the welfare of families during the separation, especially for soldiers drawn from outlying areas. This was frequently related to the loss of services in some communities as a direct function of the drawdown of Army forces in Europe. Soldiers rated their personal morale somewhat higher than unit morale in the pre-deployment period, and a majority rated unit cohesion level as only moderate.

During the mid-deployment phase, a critical stress factor was the lack of meaningful activities to engage in. This was frequently described as "boredom." In fact, the patient load on the hospital was not severe, and travel restrictions prevented U.S. medical personnel from doing outreach and liaison work in any of the forward sectors. There was also a growing sense of isolation associated with the perceived lack of responsiveness of rear support elements to requests for supplies and replacement personnel. This was apparently exacerbated by a lack of media attention to the UNPROFOR medical support mission. For many of the married soldiers, concern for families back home was a major issue. Finally, many perceived an unfair distribution of resources, such as special U.N. pay, awards, supplies, and access to vehicles, leading to a sense of relative deprivation.

The key stressors in the final period, just two-weeks before scheduled re-deployment to Germany, also had to do with uncertainty and ambiguity. The future basing of the unit was unknown, leaving many soldiers wondering where they would re-deploy to, and whether they would have to move their families. There was a continued sense of relative deprivation, and ambiguity about the mission itself and its value. While the opportunity to treat a small number of civilian "humanitarian" patients at the hospital was welcomed by the staff, it also led to increased questions about why more humanitarian medical care could not have been accomplished. During this period there was also an increased security threat, as nearby targets came under Serbian artillery attack. This clearly increased tension levels for a time, although it had some positive effects as well. It added a sense of realism to the environment, and the greater media attention that followed was generally welcomed by the soldiers. It may also have worked to increase unit cohesion, as soldiers labored together to strengthen perimeter defenses in the face of a common external threat.

For illustrative purposes, Figure 2 displays a simple listing of the principal identified stressful items across the second medical support contingent. Similar stressors were noted in the other samples examined. A rational analysis of these various lists of stress sources for soldiers led to a model of five general psychological dimensions that summarize the specific stressors encountered by soldiers on peacekeeping operations (Figure 3). This model serves to organize the data and leads to hypotheses for further testing. Figure 4 displays the mean ratings for the top five stressors reported by the second medical support contingent. Figure 5 shows the correlations between overall stressors reported and two important outcome indicators, depression and symptomatology, across all five samples. It is clear that stress exposure is strongly related to both depression and psychiatric symptomatology.

Figure 6 displays a typical finding with respect to the relation between stress on peacekeeping operations and increased alcohol use. This is an important area for additional work. Boredom is the stress dimension that is most strongly related to increased alcohol use. Figure 7 presents some additional correlations between stress exposure and the two key outcome indicators. Finally, Figure 8 provides some early recommendations for actions that can be taken to counteract the unhealthy effects of the stress dimensions identified. Future analyses are planned to statistically test and refine the early model presented here. Understanding the nature of stress encountered on peacekeeping operations is a critical first step in the larger goal of optimizing soldier health and performance under these conditions.

Overview of Research Studies Three UN Peacekeeping Deployments

Medical Support Unit #1: Operation Provide Promise

Unit deployed to Croatia, Nov 92 - May 93.
Onsite observation throughout deployment.
Surveys at mid (N = 90) & late-deployment (N = 107).

Medical Support Unit #2: Operation Provide Promise

Unit deployed to Croatia, May - Oct 93.
Onsite observation & interviews throughout deployment;
parallel family study.
Surveys at mid (N = 128) & late-deployment (N = 81).

Border Patrol Unit: Operation Able Sentry

Unit deployed to Macedonia, July 93 - Jan 94.
Survey at redeployment (N = 171) (13 Jan 94).

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FINDINGS: KEY ISSUES - STRESSORS

Summary across all phases

- * UNCERTAINTY: who is going, when, leaders, future?
- * GETTING ADAPTED, COMMUNICATION WITH HOME
- * AMBIGUOUS MISSION, CHAIN-OF-COMMAND (what are the rules?)
- * MOVEMENT RESTRICTIONS
- * LACK OF SUPPORT FROM HIGHER HQ, REAR
- * LITTLE MEDIA/PUBLIC RECOGNITION
- * RELATIVE DEPRIVATION (within Task Force & outside)
- * SHORTAGE OF MEANINGFUL PROFESSIONAL ACTIVITY (BOREDOM)
- * SHORTFALLS IN FAMILY SUPPORT
- * GROWING DOUBTS ABOUT VALUE OF MISSION
- * UNCERTAINTY ABOUT THE FUTURE FOR UNIT, INDIVIDUALS

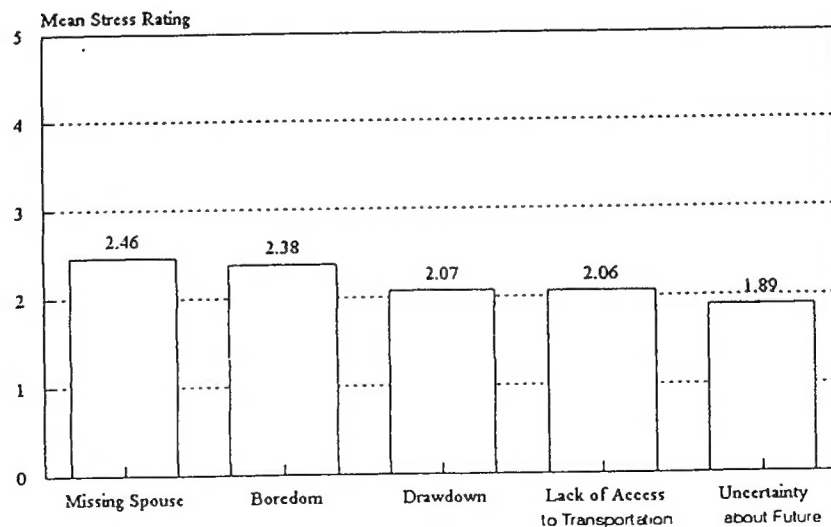
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A Model for Psychological Issues in Peacekeeping Operations

- **Isolation:** Physically Remote
Communication Difficult
Culturally Different
Newly Configured Units
- **Ambiguity:** Mission Definition
Command Structure Confusion
- **Powerlessness:** Rules-of-Engagement Restrictions
Limited Activity/Productivity
Cultural/Language Differences
Relative Deprivation
- **Boredom:** Repetition & Predictability
Lack of Work
Change in Expectations
- **Threat/Danger:** Threat to life or limb
Mines, Snipers, Disease

3

Top Stressors Reported Medical #2: Mid-deployment



N=128.

4

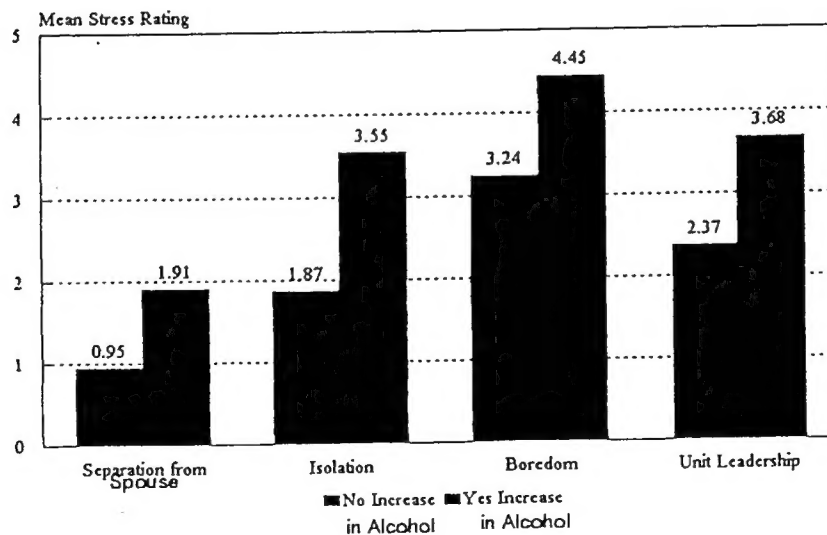
Total Stress Levels and Outcomes Correlations from Five Samples

Sample	11-item Depression Scale	20-item General Symptom Scale
Med 1: mid-deploy	.40 **	n/a
Med 1: late-deploy	.38 **	.47 **
Med 2: mid-deploy	.55 **	.53 **
Med 2: late-deploy	.43 **	.43 **
Obs 1: redeploy	.31 **	.22 *

* $p < .01$. ** $p < .001$.

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Increased Alcohol Use & Stressors Operation Able Sentry



All differences $p < .05$. $N = 171$.

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Stressors & Symptoms: Med2 Late-deploy.

Stressors	Depression	Symptoms
Personal Health Problems	.49 **	.52 **
Boredom	.49 **	.41 **
Rear Detachment	.38 **	.41 **
Family Safety	.36 *	.40 **
News about Former Yugoslavia	.35 *	.42 **
Unit Leadership	.32 *	.27
Isolation	.31 *	.24
Moving Family to U.S.	.31 *	.38 **
Marital Infidelity	.29 *	.38 *
Marital Problems	.25	.36 **
Delays in Receiving Mail	.24	.31 *

**p<.001 *p<.01 N=68.

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Psychological Issues in Peacekeeping Ops: Recommendations

- Isolation: Pre-deployment Information
Exit Briefings from Senior Units
Pre-deployment Cohesion Activities
Alternative Communication
- Ambiguity: Clear Definition
Briefings on Command Structure
Communicating Changes (Commander Calls)
- Powerlessness: Establish Rules-of-Engagement
Clear Chain of Command
Frank Discussions on Benefits
- Boredom: Creative Training
Exchange Programs with Other Forces
Self-Improvement Activities
Responsible Use of Alcohol
- Threat/Danger: Good Training, Equipment, Policies
Well-Informed Soldiers

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